FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

October 25, 2019

Utah Department of Health
Division of Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Jennifer Meyer-Smart

Dear Ms. Meyer-Smart:

Families USA appreciates the opportunity to provide comments on Utah's proposed amendment to the Primary Care Network Section 1115 Demonstration Waiver.

Families USA is a national health care advocacy organization that supports policies and programs at the state and federal levels to expand access to high quality, affordable health care, with a particular focus on policies that affect lower-income individuals.

Multiple elements of this proposed amendment are both legally problematic and poor policy choices for the state. We support Utah's decision to accept federal funds to expand Medicaid eligibility and to provide additional services to vulnerable beneficiaries. We encourage the state to fully expand as soon as allowable consistent with state legislation. However, to receive those additional federal funds, states must comply with the requirements of the Medicaid program and Medicaid law. Much of Utah's request fails to meet that test. The specific provisions of this proposal are discussed in greater detail below.

Comments on Specific Provisions in the Amendment Request

We support the following provisions that expand coverage and services:

1. ***Full Expansion up to 138% FPL by January 1, 2020***

   We support the state's decision to expand vital Medicaid coverage to thousands of low-income Utahns. The state estimates that full expansion would serve over 115,000 individuals within the first six months after implementation including approximately 40,000 newly enrolled individuals with incomes between 101 and 138% of the federal poverty level (FPL), approximately 60,000 individuals with incomes between 0 and 100% of the FPL (37,000 were already enrolled under the expensive "bridge" partial expansion plan that was implemented in April 2019), and approximately 14,000 "targeted adults" with complex needs, described in further detail below.

   Pursuing a full Medicaid expansion is a more fiscally responsible way for Utah to spend taxpayer dollars. Expanding Medicaid up to 138% FPL will guarantee the state an enhanced federal match of 90%, meaning the state is only responsible for 10% of Medicaid costs, compared to the current matching rate in which the state is responsible for roughly 32% of cost and the federal government covers only 68%. Currently, Utah is actually spending more to cover far fewer people. If the state fully expanded Medicaid and received the enhanced federal match, it could cover every resident in the 0 to 138% FPL adult expansion group for $1 million less per month

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than what it currently spends to cover the 0 to 100% FPL group. At a recent Utah Health Reform Task Force meeting, the Utah Department of Health reported that the state is paying an extra $2.5 million every month the state refuses to fully expand Medicaid.[1] An analysis from Families USA, based on Utah's own enrollment and trend projections, found that the figure is actually closer to $6.6 million per month.[2]

Given the major costs associated with delaying expansion, we encourage the state to pursue full expansion as soon as possible to take advantage of the enhanced federal match. The state should submit a state plan amendment (SPA) to expand coverage as an accompaniment to the 1115 amendment application. Compared to an 1115 waiver, the timeline for submission and approval of Medicaid expansion via SPA is faster and less administratively burdensome for both state and federal officials.[3] This SPA will ensure that the state can begin implementing the expansion provision as soon as CMS responds to the state's request for approval of the 1115 waiver amendment.

2. ***Expansion of the Targeted Adult Group***

We support the state's decision to make an estimated 7,000 more individuals eligible for the "Targeted Adult Group" and to set aside additional funds to finance their health and social needs. For these particularly vulnerable individuals, Medicaid coverage is vital. Individuals eligible for coverage in the "Targeted Adult Group" include those who are experiencing homelessness, are justice-involved with a behavioral health issue, or have serious behavioral health issues. Coverage for this population includes 12 months of continuous eligibility and dental benefits for enrollees who are receiving substance use disorder treatment.

However, we oppose the state's request for authority to arbitrarily suspend enrollment for each population group within Targeted Adult Medicaid. We recommend that, prior to submission to CMS, the state remove from its application the request to suspend enrollment for populations in the Targeted Adult Group.

3. ***Housing-Related Services***

We support the state's decision to use Medicaid funds for housing-related supports such as education on tenant rights, one-time security deposits, purchase of basic household items, and coordination of services to help thousands of beneficiaries individuals secure, establish, and maintain a safe and healthy living environment. The state estimates that tenancy support services would benefit an estimated 5,000 individuals, community transition services would benefit an estimated 5,000 individuals, and supportive living/housing services would benefit an estimated 1,000 individuals.

[1] https://www.deseret.com/utah/2019/8/22/20828699/utah-full-medicaid-expansion-after-latest-federal-government-rejection
[2] https://familiesusa.org/resources/utah-wastes-6-6-million-every-month-by-refusing-to-fully-expand/
[3] https://familiesusa.org/wp-content/uploads/2019/01/MCD_Intro-Expansion_Fact-Sheet.pdf

However, we oppose the state's request for authority to arbitrarily suspend housing-related supports via administrative rulemaking. The state provides no rationale for this provision and does not make clear which services would be subject to the suspension, or when. We recommend that, prior to submission to CMS, the state remove from its application the request to suspend housing-related supports.

We oppose the following provisions:

1. ***Work Reporting Requirements***

Utah received approval from CMS to implement a work reporting requirement for its "Adult Expansion" population in March 2019, as part of a previous amendment to its "Primary Care Network" 1115 waiver. In accordance with state legislation (S.B. 96), Utah is proposing to continue its authority to implement the work reporting requirement as part the "Fallback Plan" amendment. Utah requires Medicaid beneficiaries who are subject to the work reporting requirement to: register for work through the state system; complete an evaluation of employment training needs; complete job training modules; and apply with at least 48 potential employers. If a beneficiaries fail to complete the required reporting activities or fails to qualify for an exemption within a three-month period, they lose Medicaid eligibility and coverage.

While we understand that, in accordance with S.B. 96, implementation of the Medicaid expansion provision as part of the "Fallback Plan" waiver amendment is contingent on CMS's approval of this work reporting requirement, we still contend that work reporting requirements are bad policy that should not be implemented. As we have outlined in numerous comments, including our comments on the new "Utah Per Capita Cap 1115 Demonstration" waiver and the previous amendment to the "Utah Primary Care Network" waiver, a work reporting requirement will result in coverage losses and is in conflict with Medicaid's objectives.[4] Approval of a work reporting requirement request would constitute an abuse of Section 1115 demonstration authority.

Thousands of Medicaid beneficiaries are projected to lose coverage due to the state's proposed work reporting requirements.

The state does not provide a direct estimate of coverage losses that will result from the work reporting requirement. However, they do provide an estimate of the percentage (70%) of the adult expansion population who will be exempt from the requirement. They also estimate the percentage (75-80%) of non-exempt beneficiaries who will comply with the requirement. Based on these estimates and the state's estimated number of enrollees in Demonstration Year 18 (excluding the Targeted Adults), we have determined that between 6,147 and 7,684 Medicaid beneficiaries will

[4] See Families USA's August 4, 2018 comments on the proposed amendment to the "Utah Primary Care Network" waiver, available online at https://familiesusa.org/wp-content/uploads/2019/10/Families_USA_comments_Utahs_Waiver_amendment_August_2018_cfp.pdf

See Families USA's June 28, 2019 state-level comments on the proposed "Utah Per Capita Cap 1115 Demonstration" waiver, available online at https://familiesusa.org/wp-content/uploads/2019/10/Families-USA-State-Comment-Letter-on-Utah-Per-Capita-Cap-1115-Application.pdf

neither comply with, nor be exempt from the requirements and will consequently lose coverage in the first year of the demonstration.

As seen in other states, the biggest driver of disenrollment is the burden of reporting compliance with or exemption from work requirement. In Arkansas, the only state at this point to have disenrolled beneficiaries for failure to comply with its Medicaid work reporting requirement, more than 18,000 people lost coverage in only a few months. Enrollees faced disenrollment due to the challenges associated with reporting their work or exempted status. In a study published in *The New England Journal of Medicine* (*NEJM*) in June 2019, researchers from Harvard T.H. Chan School of Public Health found that over 95% of enrollees subject to Arkansas' work reporting requirement were participating in qualifying activities or should have been exempt.[5] But thousands of enrollees still lost coverage, not because they weren't working, but because they were "unaware of the policy or were confused about how to report their status to the state." A recent report from the Urban Institute also found that "structural barriers and administrative challenges further inhibited compliance" with the work reporting requirement.[6] Beneficiaries had difficulty navigating the complicated reporting system and many lost coverage even though they were eligible.

Similarly, in New Hampshire, the state attempted to inform beneficiaries of the reporting requirement, but failed to obtain compliance information for nearly 17,000 beneficiaries who were at risk of losing coverage. As a result, the state decided to delay implementation of its work reporting requirement program due to the expected coverage losses.[7]

On behalf of beneficiaries who risk losing coverage due to work reporting requirements, a lawsuit was filed to challenge CMS's approval of both Arkansas' and Kentucky's work reporting requirement waivers. U.S. Federal Judge James Boasberg vacated the approval of Arkansas' and Kentucky's waivers as a violation of the federal statutory requirement that Medicaid waivers promote the core objectives of the Medicaid program (i.e. furnishing medical assistance). A similar lawsuit was filed to challenge CMS's approval of New Hampshire's work reporting requirement waiver and that approval was vacated as well.

A work reporting requirement will cost millions of dollars to implement.

This month, the United States Government Accountability Office (GAO) released a report that included five states' estimates of the administrative costs associated with implementing their approved work reporting requirement waivers.[8] Estimated costs varied from $6 million to $271

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[5] Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements — Results from the First Year in Arkansas," *The New England Journal of Medicine* Special Report, June 19, 2019, https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.

[6] https://www.urban.org/research/publication/lessons-launching-medicaid-work-requirements-arkansas

[7] Jeffrey A. Meyers, New Hampshire Department of Health and Human Services, to Gov. Christopher T. Sununu, Donna M. Soucy, and Steve Shurtleff, July 8, 2019, https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf.

[8] https://www.gao.gov/assets/710/701885.pdf

million for IT systems changes, beneficiary outreach, contracting and other administrative costs. Much of these costs do not appear to be allowable for enhanced federal match and would therefore require significant state spending.

Despite the astronomical costs associated with implementing these waivers, the GAO found that states were not required to provide projections of administrative costs when requesting approval of these waivers. Therefore, in the interest of transparency with regards to state and federal spending, we request that the state include projections of administrative costs associated with implementing this waiver.

A work reporting requirement is contrary to Medicaid law.

The relevant statutory provisions for this analysis are Section 1115 of the Social Security Act and section 1901 of the Act. Section 1115, "Demonstration Projects," outlines the Secretary's authority to grant demonstration waivers. Section 1115 gives the Secretary the authority to "waive compliance with any of the requirements of section […] 1902" of the Social Security Act for any experimental, pilot, or demonstration project which, in the judgment of the Secretary, "is likely to assist in promoting the objectives of title […] XIX."[9]

Section 1901, "Appropriations," states the purpose of federal Medicaid funding, i.e., the program's objectives referred to in section 1115. It states that federal Medicaid dollars are for the purpose of enabling states "to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care…."[10] In the context of the statute, it is absolutely clear that "independence or self-care" refers to federal funding enabling states to provide care that can help individuals attain or retain physical independence.

While HHS has updated its Medicaid.gov website to redefine the objectives of the Medicaid program, that has no legal import. Statutory language has precedence over any website language, no matter how official the website.

- A work reporting requirement is unrelated to Medicaid's objectives as defined in statute. The language in the statute is clear. Federal Medicaid dollars are to be used to *furnish* medical, rehabilitation, and long-term services. Requiring work or community service as a condition of program participation is not in any way related to the *state furnishing* medical services or to the *state furnishing* rehabilitative or other services—indeed it achieves the opposite goal by withdrawing medical and rehabilitative services from otherwise eligible low-income people if they do not meet the work reporting requirement. It is therefore outside of CMS's authority to approve under section 1115 authority.

  In his recent ruling to vacate the approval of Arkansas' waiver amendment to work reporting requirement, Judge Boasberg affirmed that a work reporting requirement is unrelated to

[9] Social Security Act, section 1115 [42 U.S.C. 1315].
[10] Social Security Act Sec. 1901. [42 U.S.C. 1396].

Medicaid's objectives. Boasberg ruled that, "the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address – despite receiving substantial comments on the matter—whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy."[11]

- Adding a work reporting requirement is beyond the Secretary's authority to "waive" requirements in section 1902. Section 1115 gives HHS the authority to waive requirements in Section 1902. It does not allow states to add new program requirements that are not mentioned in 1902 and that are unrelated to the program's statutory purpose of furnishing medical or rehabilitative services. Section 1902 does not mention engaging in work or community service. States do not have the authority to add new requirements unrelated to the program's objective of *furnishing* medical care.

- A mere nexus between an activity and health is not a sufficient basis for the Secretary to use 1115 authority to make Medicaid eligibility conditional upon participation in that activity. In its request, Utah's rationale for adding a work reporting requirement to Medicaid is that "many studies have concluded that employed individuals have better physical and mental health, and are more financially stable than unemployed individuals."[12] While that may be true, the mere connection between an activity and health status is not a basis to make Medicaid eligibility conditional upon an individual's participation in that activity. There are numerous activities that have been shown to improve physical and mental health: diet[13]; exercise[14]; marital status[15]; social engagement[16]; to list only a few of the nearly endless activities that can impact individual health.

  It is gross regulatory overreach and a misuse of federal and state funds to add extra-statutory conditions on Medicaid eligibility that are not within the program's objectives simply because one or more of those activities have been shown to be related to individual health.

  Medicaid is a program to furnish medical assistance: it is a health *insurance* program. Health insurance protects people from financial loss associated with medical costs. That is not

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[11] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58, page 26.
[12] Utah's Per Capita Cap Section 1115 Demonstration Waiver Application, page 8.
[13] See the U.S. Dietary Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between diet and health, at https://health.gov/dietaryguidelines/2015/guidelines/introduction/nutrition-and-health-are-closelyrelated/.
[14] See the U.S. Physical Activity Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between physical activity and health, at https://health.gov/paguidelines/
[15] For a summary of the copious data on this topic, see the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Research Brief, 7/01/2007 online at https://aspe.hhs.gov/report/effects-marriagehealth-synthesis-recent-research-evidence-research-brief.
[16] For a summary of the data on the connection between social relationships and health see Debora Umberson, et al., "Social Relationships and Health: A Flashpoint for Health Policy," Journal of Health and Social Behavior, 2010; 51 (Suppl): S55-S66, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150158/.

synonymous with health. That distinction holds true for Medicaid, Medicare, employer sponsored coverage, and any health insurance program. Following a path of adding reporting requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a virtual a la carte menu of extra-statutory requirements approved at any administration's whim. It sets up a dynamic that could lead to near unending government micromanagement of the lives of Medicaid enrollees.

Judge Boasberg affirmed that promoting health is not a freestanding objective of Medicaid in his ruling to vacate the approval of Kentucky's work reporting requirement waiver. In his decision, Boasberg notes that, were health to be considered a freestanding objective of Medicaid, "nothing would prevent the Secretary from conditioning coverage on a special diet or certain exercise regime."[17] He also notes that, "Even if health were such an objective, approving Kentucky HEALTH on this basis would still be arbitrary and capricious. The Secretary, most significantly, did not weigh health gains against coverage losses in justifying the approval."[18] If approved, the same could be said for Utah's waiver to add a work reporting requirement, given that it would similarly result in a loss of coverage.

- <u>The connection of an activity to greater financial stability is also not a sufficient basis for the Secretary to use 1115 authority to add that activity as a requirement for Medicaid eligibility.</u> Utah cites the connection between work and improved financial stability as support for Medicaid work reporting requirements. While a laudable public policy goal, improved financial stability for low-income people is not an objective of the Medicaid program. Indeed, even if it were, there is data showing that expanding Medicaid coverage per se improves the financial health of those gaining coverage by protecting them against out-of-pocket medical costs.[19]

  Judge Boasberg also noted in his ruling to vacate the approval of Kentucky's work reporting requirement that financial stability is not an objective of Medicaid. He states, "financial self-sufficiency is not an independent objective of the [Social Security] Act and, as such, cannot undergird the Secretary's finding under § 1115 that the project promotes the Act's goals."[20]

- <u>Evidence from other programs indicates a work reporting requirement in Medicaid will not result in sustained increased employment.</u> Evidence from work requirements in other social services programs indicates that they do not result in sustained employment and that any

[17] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 27.
[18] *Idem*, page 28.
[19] See: Kenneth Brevoot, et al., "Medicaid and Financial Health," the National Bureau of Economic Research Working Paper 24002, Issued November 2017, online at http://www.nber.org/papers/w24002.pdf; Luojia Hu, et al, "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing," the National Bureau of Economic Research Working Paper 22170, Issued April 2016 and revised August 2017, online at http://nber.org/papers/w22170; Nicole Dussault, et al., "Is Health Insurance Good for Your Financial Health?" Liberty Street Economics, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-healthinsurance-good-for-your-financial-health.html#.V2fhz_krLct.
[20] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 29.

employment increases faded over time.[21] In fact, individuals with the most significant barriers to employment often do not find work.[22]

There is reason to believe that results in Medicaid will be no different. No data supports the theory that taking health insurance away from low-income people will improve their health, finances, or employment prospects. In fact, a recently published study in the New England Journal of Medicine measured the effect of Arkansas' work reporting requirement on insurance coverage and employment in the state. The study concluded that implementation of the work reporting requirement resulted in no significant changes in employment, but did result in Medicaid coverage losses and an increase in the percentage of uninsured people in the state.[23,24]

2. *Mandatory Enrollment in Employer-Sponsored Insurance*

As part of a previous amendment to its "Primary Care Network" 1115 waiver, Utah received approval from CMS in March 2019 to require Adult Expansion beneficiaries who are eligible for employer-sponsored insurance (ESI) to purchase that coverage instead of enrolling in Medicaid. In accordance with state legislation (S.B. 96), Utah is proposing to continue its authority to mandate enrollment in ESI.

While we understand that, in accordance with S.B. 96, implementation of the Medicaid expansion provision as part of the "Fallback Plan" waiver amendment is contingent on CMS's approval of this ESI enrollment requirement, we still contend that mandated enrollment in ESI is bad policy that should not be implemented. Utah estimates approximately 14,000 to 19,000 individuals will be eligible for an ESI plan and will enroll in that plan instead of Medicaid. If these beneficiaries fail to enroll in ESI, they will lose Medicaid coverage. We are concerned with the potential administrative costs and burdens associated with determining who is eligible for ESI coverage and tracking enrollment in that coverage, especially since ESI falls outside the Medicaid program. Implementation of this provision will require substantial data matching and interagency collaboration. Failure to properly implement this provision could have devastating consequences for beneficiaries. If the state erroneously determines that an individual qualifies for ESI and terminates their Medicaid eligibility, that individual will lose access to health insurance coverage.

3. *Enrollment Limits*

Utah is once again requesting to limit enrollment for its Targeted Adult and Adult Expansion Medicaid populations. This proposal, which has been previously denied by CMS, would offer Utah another way to cut off Medicaid to eligible individuals. The proposed enrollment limits would take

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[21] LaDonna Pavette, *Work Requirement Don't Cut Poverty, Evidence Shows* (Washington, DC: Center of Budget and Policy Priorities, June 2016) online at https://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf

[22] *Ibid.*

[23] Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements — Results from the First Year in Arkansas," *The New England Journal of Medicine* Special Report, June 19, 2019, https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.

effect, “when projected costs exceed annual state appropriations.” In other words, the state has the ability to prevent eligible Utahns from enrolling in Medicaid and keep them uninsured whenever the state’s Medicaid costs exceed the amount of funding appropriated by the executive and legislative branch.

Utah’s request to apply “enrollment limits” mirrors its August 2019 proposal to implement an enrollment cap, which was denied by CMS. In an August 16, 2019 letter to the state, CMS explained that the proposed enrollment caps, “have the effect of limiting enrollment to less than the full group otherwise eligible for Medicaid, which would be tantamount to ‘partial expansion.’ ” CMS noted that the state will not be eligible for enhanced match if enrollment in the new adult group is limited.[25]

Federal statute requires that in order to receive an enhanced federal match, a state must cover *all individuals* in subclause (VIII) of section 1902(a)(10)(A)(i). "All" in the context of the statute is not an ambiguous term. The statute does not allow for partial expansion, limited enrollment, or other non-statutory diminutions in the covered population.

The statute defines the expansion group as a mandatory group in its entirety. The Supreme Court’s decision in National Federation of Independent Business v. Sebelius (NFIB) made the Affordable Care Act’s (ACA’s) Medicaid expansion an option for states.[26] However, that same decision also made clear that when a state accepts the option to expand Medicaid, the requirements related to the ACA’s Medicaid expansion still apply.[27] In other words, the decision did not affect any other application of the statute to the expansion group. Once a state decides takes up the option to expand Medicaid at the enhanced federal matching level, it must follow all of the requirements in the statute in order to receive that enhanced federal match.

It is not within CMS’s authority to waive the definition of the expansion population, the group to which the enhanced federal match applies. That definition is codified in section 1905 of the Social Security Act. That section of the Act is not within section 1115 waiver authority

More broadly, the absence of enrollment limits for statutory Medicaid populations is a legal pillar of the Medicaid program and its role in the health care of low income people. The prohibition on enrollment caps cannot be waived consistent with the statutory directive that 1115 demonstrations promote the objectives of Medicaid. Indeed, enrollment limits do not promote the primary objective of the Medicaid program. Preventing Medicaid-eligible people from enrolling in affordable health care coverage is the very opposite of furnishing medical assistance.

Given that this provision is in violation of federal statute, does not promote the primary objective of Medicaid, and has been previously denied by CMS, we recommend that, prior to submission to CMS, the state remove from its application the request to apply enrollment limits.

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[25] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/per-capita-cap/ut-per-capita-cap-correspondence-ltr-20190816.pdf

[26] *NFIB –v- Sebelius*, 567 U.S. 519 (2012).

[27] *Ibid*. Noting that the law allows the Secretary to withhold all Medicaid funds from a state if it is not in compliance with Medicaid requirements, including those applying to the expansion.

4. ***Waiver of EPSDT***

Utah received approval from CMS to cut Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for adults ages 19 and 20 in its expansion population and targeted adult population in March 2019, as part of a previous amendment to its "Primary Care Network" 1115 waiver. The state is proposing to continue this authority as part the "Fallback Plan" amendment. EPSDT covers items such as vision and hearing screening and treatment (e.g., glasses or hearing aids), basic dental, medical, mental health, and developmental services for children and young adults. Congress designed Medicaid with the EPSDT requirement because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives.

There is a real health benefit to extending EPSDT to age 21. The brain does not develop fully until children reach about age 25.[28] As a result, young adults benefit from frequent screenings and access to comprehensive treatment as their medical needs, particular mental health needs, continue to change. Furthermore, EPSDT is cost effective. EPSDT provides sweeping benefits for all Medicaid enrollees under age 21, but it is not a high-cost service. Removing the EPSDT benefit for 19- and 20-year-olds would not produce large savings, and would make it more difficult for these young adults to receive the care they need.

One important piece of EPSDT that would also be eliminated for 19 and 20 year olds is dental care. Utah recognizes the importance of dental care in its previously approved waiver request to provide dental coverage to people in SUD treatment. It makes no sense to simultaneously eliminate dental care for young adults, ending the investment the state has made in oral health for this population. The condition of a person's mouth and teeth impacts his or her ability to get a job as well as the person's overall health[29], and Utah's attempt to roll back oral health care runs counter to the state's goals laid out in its previous waiver request.

The state has provided no justification for waiving vital EPSDT benefits. We recommend the state discontinue its authority to waiver EPSDT benefits under its current waiver and remove this provision from its amendment application prior to submission to CMS.

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[28] Massachusetts Institute of Technology, Young Adult Development Project, online at http://hrweb.mit.edu/worklife/youngadult/brain.html.

[29] Utah notes in its SUD waiver that its evaluation of a HRSA grant found dental care to make a difference in employment.
Also see ADA Health Policy Institute, Oral Health and Well-Being in the United States, 2016, available online at https://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being;
M.K. Jeffcoat, et al "Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions." American Journal of Preventive Medicine 47(2)(2014):166–74;
A. Marano, et al, "Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Bloomfield, CT: Cigna, 2013; United Healthcare, Medical Dental Integration Study, 2013;
Nasseh, Vujicic and Glick, "The Relationship between Periodontal Interventions and Healthcare Costs and Utilization," Health Economics, January 22, 2016;

5. ***Lock-out Periods for Program Violations***

Also in accordance with state legislation, Utah is also proposing a six month "lock-out" or temporary disenrollment for beneficiaries who commit a "program violation." The state's definition of "program violation" includes failure to provide documentation to the state of changes in income within 10 days, a requirement that is extraordinarily difficult for households of any income level to meet and that will predictably lead to high levels of disenrollment. If the state imposes an enrollment limit while a beneficiary is suspended for an intentional program violation (IPV), the beneficiary is not allowed to re-enroll in Medicaid until an open enrollment period begins.

While we understand the state is required, in accordance with S.B. 96, to include this provision in its "Fallback Plan," we still contend that this is bad policy that should not implemented. Lock-outs for "program violations" will result in coverage losses. The state anticipates 750 individuals per year will lose Medicaid eligibility as a result of these lock-outs.

In addition to resulting in coverage losses, the proposed lockouts for IPV are extra-statutory and administratively burdensome. The state notes in its application that the Utah Attorney General's office already has a process for determining and prosecuting severe IPVs that could constitute Medicaid fraud. Medicaid eligibility is not a tool for enforcing program fraud issues, and most of the violations described under the IPV narrative do not constitute fraud.

6. ***Waiver of Presumptive Eligibility***

Also in accordance with state legislation, Utah is proposing to eliminate presumptive eligibility for all expansion populations, restricting a pathway to Medicaid coverage for approximately 500 to 750 individuals per month.[30] While we understand the state is required, in accordance with S.B. 96, to include this provision in its "Fallback Plan," we still contend that this is bad policy that should not implemented.

Currently, under federal law hospital staff can make a preliminary eligibility determination for uninsured patients that need care. After a patient is deemed "presumptively eligible," the state performs the full eligibility process to determine if they can continue to receive Medicaid benefits. Presumptive eligibility helps patients get health care as soon as they arrive at the hospital and ensures that doctors and hospitals are reimbursed for that care. By waiving presumptive eligibility, the state would create additional barriers for uninsured patients who receive care at hospitals.

Because Utah has already waived retroactive eligibility for beneficiaries between 0% and 100% FPL and plans to waive retroactive eligibility for beneficiaries between 101% and 138% FPL, uninsured patients who visit the hospital will be responsible for the entire cost of their care, even if they could have been determined eligible during their visit or retroactively after receiving care. A waiver of both retroactive and presumptive eligibility eliminates a vital pathway for hospitals to be

[30] The state already does not allow presumptive eligibility for its targeted adult population.

reimbursed after caring for low-income, uninsured patients and for uninsured patients to avoid crippling financial liabilities.

In effect, a waiver of presumptive eligibility is another way for the state to cut Medicaid costs. Beneficiaries who are determined eligible for Medicaid while receiving care in a hospital are more likely to have an above average per member per month cost, since a claim will be generated as soon as the beneficiary is determined eligible for Medicaid.

*7. **Premiums and Cost Sharing***

Also in accordance with state legislation, the state is proposing that individuals in the expansion population with incomes above 100% of the FPL will be required to pay monthly premiums and copayments for non-emergent emergency department (ED) visits. While we understand the state is required, in accordance with S.B. 96, to include this provision in its "Fallback Plan," we still contend that this is bad policy that should not implemented.

Single individuals will be required to pay $20 per month in premiums, and married couples will be required to pay $30 per month. Beneficiaries who fail to pay their premiums face disenrollment from Medicaid. Utah estimates approximately 40,000 individuals will be required to pay a monthly premium. The state estimates that 3%, or 1,200 individuals, will lose coverage due to failure to pay the monthly premium. Medicaid beneficiaries are financially strained already.[31] Forcing them to spend what little money they have left on premiums can make their health care unaffordable.

Additionally, the state will require a $25 copay for non-emergent ED visits. This provision has historically been difficult to implement compared to other less punitive strategies to divert unnecessary utilization of the ED. Additionally, high copays for non-emergent use of the ED could deter individuals from appropriate use of emergency services, in addition to inappropriate use.

*8. **Additional State "Flexibilities"***

Utah is requesting numerous additional provisions that allow the state to limit coverage or benefits through the rulemaking process, instead of through the section 1115 waiver process. These provisions include:

- Delaying enrollment for eligible expansion adults with incomes between 101% and 138% FPL. Beneficiaries will no longer be immediately eligible for Medicaid coverage to cover recent medical expenses, and must instead wait until the first of the month for coverage to begin. Under this provision, it is estimated that beneficiaries will lose about one month of coverage in their 12-month eligibility period, which can seriously threaten their health and financial stability
- Eliminating retroactive coverage for individuals between 101% and 138% FPL. This provision further limits coverage for beneficiaries, who are made responsible for the entire cost of their care, even if they could have been determined eligible during their visit or retroactively after receiving care.

[31] https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty

- Reducing the benefit package for adults with dependent children. For this population, comprehensive benefits are particularly vital.
- Making enrollment in an integrated plan or other managed care plan mandatory or optional for different adult expansion groups. The state does not provide detail on who is subject to mandatory enrollment and when.
- Additional managed care flexibilities:
    - Demonstrating actuarial soundness of rates without prospective review from CMS
    - Implementing contracts and rates prior to formal approval from CMS
    - Implementing directed payments prior to formal approval from CMS
    - Adopting an approach to network adequacy, access to care, and availability of services. It remains unclear how the proposed approach differs from CMS's approach to network adequacy, access and availability; if this new approach replaces CMS's approach; and what authority is needed, if any.

We recommend the state remove these provisions from its application prior to submission to CMS.

Conclusion

It has been nearly a year since the people of Utah voted to fully expand Medicaid. This "Fallback Plan" amendment finally proposes a pathway to expanded Medicaid coverage, but it comes at a significant cost to Utahns whose benefits and coverage may still be compromised by many of the other provisions included in the state's proposal.

While we understand that, in accordance with S.B. 96, implementation of the Medicaid expansion provision as part of the "Fallback Plan" waiver amendment is contingent on CMS's approval of the work reporting and ESI enrollment requirements, we still contend that these provisions jeopardize beneficiaries' coverage and should not be implemented. We understand that S.B. 96 also requires the state to include provisions such as lock-outs for program violations, a waiver of presumptive eligibility, and additional premiums and cost sharing, but these provisions will also negatively impact beneficiaries and should not be implemented.

Bearing in mind the requirements in S.B. 96, we encourage the state to expedite its proposal to expand Medicaid up to 138% FPL by submitting a SPA that makes Medicaid expansion effective as soon as CMS responds to the state's request for approval of the work reporting requirement and mandatory enrollment in ESI. Utahns voted for a full Medicaid expansion and the state should implement this full expansion as soon as possible.

Thank you for your consideration of these comments. If you have any questions, please contact Emmett Ruff at ERuff@familiesusa.org or 202-628-3030.

Respectfully submitted,

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